ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996 45 C.F.R. § 164.508

Name of person/organization disclosing health information:
DIVISION OF DEVELOPMENTAL DISABILITES

Name of individual/client whose specific health information is being disclosed:

Describe health information to be disclosed:
Support Coordinator name and contact information

Name of person/organization receiving the health information:
Peoria Unified School District

Describe the specific purpose of this release. The statement "at the request of the individual" is sufficient when an individual initiates the authorization.
To schedule transition team meetings

This authorization's expiration date, event, or condition:
ONE YEAR FROM DATE OF AUTHORIZATION.

If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.

I understand that I may revoke this authorization at any time by written notice to the person/organization name above that is disclosing my health information, except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation.

I understand that I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

See reverse for EOE/ADA/LEP disclosures

I understand that once the records and information authorized herein are disclosed, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, health care service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.

I understand that I may have a copy of this signed authorization if I request it.

_____ _____

Print full name of individual/client or personal representative *Date signed*

_____

Signature of individual/client or personal representative

_____

Description of personal representative's authority *(if applicable)*:

_____

**Note: This authorization was revoked/withdrawn in writing on (date):* _____

_____

Signature of staff

A Facsimile or Photocopy of this Authorization is Considered to be as Authentic as the Original.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.